Egg Donor Info & Consent

**These template documents were revised before the US Supreme Court decision in *Dobbs v. Jackson* (which repealed Roe v. Wade), and therefore, SART has not reviewed the template documents and did not make any changes based on the *Dobbs* decision. SART strongly recommends that before any SART template document is put into use in a Member's practice, the document should be reviewed by the Member's local legal counsel to ensure that the language conforms to current federal, state and local laws as these may have recently changed or are in the process of being changed.**

DESCRIPTION

This document informs Egg Donors about the Egg Donation in detail, including its risks to her. It then asks the egg donor to consent to this therapy, and to agree to certain requirements of donation.

TARGET

* All women donating eggs

RELEASE NOTES

* This is the 2nd revision of this document
* Risks to donor updated based on current literature
* Page 1 identifies the donor and whether the donation is directed or non-identified, for fresh or frozen eggs, her choice about donor identity, and whether she has restricted the use of her eggs.
* Wording shortened and simplified where possible
* Signature page allows for Witness as well as Notary verification.
* Optional language for programs permitting donors to restrict use of eggs included as last page

TO DO

* Modify this document according to local needs and preferences.
* Replace “CLINIC” with your program’s name throughout
* Get legal review to assure conformance with State and local laws and regulations.

***DISCLAIMER.***

*SART and ASRM make this template available to their member clinics (Clinics) for use as a starting point to design their own patient forms and agreements. The template and all intellectual property rights in the template are owned exclusively by SART and ASRM, and Clinics receive only a right to use the template for their own internal business purposes.* ***This template may not be shared with any non-member organizations****.*

*Neither SART nor ASRM represent or warrant that the template will meet a particular Clinic's needs or objectives or that the template with comply with all the laws, rules or regulations applicable to a particular Clinic.* ***Before using this template you should conduct a legal review to ensure the resulting document complies with all of your responsibilities; meets all applicable legal requirements; and meets all of your program's specific considerations****.*

*Neither SART nor ASRM nor any of their respective administrators, executives, employees, committees or agents make any representations or warranties with respect to the template and disclaim any and all warranties, express or implied, including, without limitation, warranties of merchantability, fitness for a particular purpose, compliance with laws, non-infringement or accuracy with respect to the template. Neither SART nor ASRM will be liable for any incidental, consequential, special, indirect, direct, business interruption, regulatory or punitive damages incurred in connection with or as a result of any claim arising out of use of or reliance on the template or the Clinic's resulting document, even if such consequences or damages were foreseeable.*

*[Without limiting the foregoing, use of the template is subject to the ASRM Website Terms and Conditions of Use and by using the template, you consent to those terms.]*

Egg Donation

Information & Informed Consent and Agreement

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Egg donation (DE) is an established treatment for intended parents who are unable to have children using their own eggs. Examples include age related reasons, genetic reasons, and some same sex couples.

Donation Type: 🞏 Non-Identified 🞏 Directed (known)

 🞏 Fresh 🞏 Egg Bank

Identity Disclosure: 🞏 None 🞏 Open 🞏 Open at adulthood

Restricted Use: 🞏 None 🞏 Research 🞏 Secondary donation

Egg Donation Overview

Donor Screening

To donate eggs, potential donors undergo genetic, psychological, ovarian reserve, and physical screening before being accepted as an egg donor. This screening process may involve several office visits over one or two months. There are 2 parts to donor screening – the recommended ASRM psychological, genetic, and hormonal screening and the FDA required infectious disease screening (physical exam, detailed questionnaire, blood tests).

Ovarian Stimulation

Fertility drugs are used to stimulate the ovaries to grow several eggs at once. Over 10 days or so, they grow to full size. Monitoring of your ovaries’ response by vaginal ultrasound and blood drawings for hormone levels is important. A typical pattern of office visits is shown below.

***Egg Retrieval***

***Ovarian Stimulation Cycle***

***Preparatory Cycle***

Office visits:

Once the ovaries have a group of mature eggs, a trigger shot will be prescribed. The timing of the trigger shot is critical.

This process does not cause you to run out of eggs sooner in the future. The eggs that grow were already ‘linked’ to this cycle and would have been naturally lost anyway.

Egg Retrieval

A transvaginal ultrasound probe is used to see the ovaries and the egg-containing follicles within the ovaries.  A long needle is guided into each follicle and the fluid is drained out.  The fluid contains the egg.

This completes the process of egg donation. About 2 weeks later your next period will begin.

Use of Eggs

Unless state law provides otherwise, the following will apply:

If you are donating to a designated Recipient, control of the eggs is under the sole control of the Recipient(s) from the moment your eggs are retrieved. If you are donating to an egg bank, the egg bank will have sole control over the use and disposition of your eggs. Recipient can use your eggs as they wish unless you restrict use.

To create embryos, sperm will be placed with or into your eggs. The resulting embryos will be frozen or transferred into a uterus (either that of an intended parent recipient or a gestational carrier) for the purpose of the Recipient(s) parenting any resulting child. Extra embryos may be frozen for later use. In some cases, the Recipient is not yet identified at the time your eggs are removed; in those cases, your eggs can be frozen and stored to be used later for others to have a baby in the future.

Consent to Donate Eggs

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, request, authorize and consent to the donation of my eggs to CLINIC, and as appropriate, its employees, contractors, consultants and authorized agents, for use by a Recipient(s) in their attempts to achieve a pregnancy.

Description of the Procedure

The following is a general outline of the steps that may be required in the process of egg donation. I consent to the performance of these steps:

* Complete history and physical examination, which will include questions about my age, travel, medical, psychological, genetic and sexual history, and my family medical and genetic history.
* Administration of fertility drugs including gonadotropins which stimulate egg growth, and other medications possibly including oral contraceptive pills, GnRH agonists, GnRH antagonists and hCG. Some of these drugs require daily injections.
* The use of blood tests to monitor hormone levels, often daily.
* Transvaginal ultrasound examinations of the ovaries to monitor growth of the developing follicles. This procedure may need to be performed daily.
* Strict adherence to the medication injection and monitoring (blood tests and ultrasounds) schedule prescribed by the physicians.
* Retrieving the eggs using ultrasound-guided transvaginal egg retrieval. This procedure utilizes anesthesia and the insertion of a needle through the vaginal wall into the ovary (ovaries) to obtain the eggs.
* The eggs may be used fresh or may be frozen for later use by the Recipient (the couple or individual who is receiving the egg donation).
* The use of antibiotics to reduce the risk of infection after the egg retrieval.
* Federally mandated screening and testing for infectious diseases performed within 30 days of the egg retrieval.
* Use of a condom throughout the treatment cycle to avoid pregnancy and possible disease transmission.

How will the eggs be used?

I understand, agree and consent that the selection of the Recipient will be determined at the sole discretion of the CLINIC, and as appropriate, its employees, contractors, and consultants, unless I have listed a specific designated Recipient couple or individual below.

Please check the appropriate choice and initial:

* The CLINIC will determine the Recipient(s) of these eggs.

Donor’s initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

* I designate the individual’s listed below as the recipient(s) of these eggs.

Designee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Donor’s initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

I understand, agree, and consent that once they have been retrieved, that I will have no further control over these eggs, *unless I choose to restrict their use in writing (see below).* The Recipient may use them in any way they think appropriate, including attempting to have a child or freezing the eggs to attempt to have a child later. I will not be notified of how or when they are used. I understand that the Recipient may decide to discard the eggs or any resulting embryos, donate them to research, or donate them to someone else in the future (“secondary donation for procreation”) and that I will not be notified of that decision or asked for my approval. I understand that the eggs may first be frozen and stored in an Egg Bank before being used by a Recipient, and that the Recipient may not yet be identified at the time of my donation. Moreover, several different Recipients may receive my eggs, or none at all.

Please check the appropriate choice and initial:

* YES: I approve of DONATION FOR RESEARCH
* NO: I do NOT approve of DONATION FOR RESEARCH

Donor’s initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

* YES: I approve of secondary DONATION FOR PROCREATION
* NO: I do not approve of secondary DONATION FOR PROCREATION

Donor’s initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Viable Eggs. I understand that some non-viable eggs may be used as a teaching aide for laboratory personnel before being discarded. I understand that non-viable eggs and embryos will be discarded according to American Society for Reproductive Medicine (ASRM) Guidelines.

Cells and Biological Materials that Would Normally Be Discarded. I understand that some cells (such as granulosa cells which are cells from the ovary that are retrieved along with eggs) and biological materials such as follicular fluid (the fluid that the egg is found in), which are normally discarded, may be used for research studies. These materials would never be used for any procedures that involve fertilization or creation of an embryo or a cell line without my written consent in advance. When these studies are completed, the materials will be discarded.

Risks of Egg Donation

Risk of Medications: Common side effects of medications used for ovarian stimulation include hot flashes, vaginal dryness, nausea, headaches, and muscle aches. Some women may retain fluid (bloating) or have moodiness. Any injection can cause bruising, redness, swelling, or pain at the injection site. In rare cases, there may be a severe allergic reaction, infection at injection sites, blood clots or stroke. Reactions may vary based upon the type woman’s underlying diagnosis/medical status and medication dosages.

Bleeding or Trauma: A small amount of bleeding may occur as the needle passes through blood vessels. The risk of significant bleeding is small (<0.1%)]. Rarely, major bleeding or serious damage to nearby organs (intestines, bladder, ureters, ovaries) may occur and require treatment such as surgery and/or hospitalization for fluid or blood transfusions.

Anesthesia: The use of anesthesia while removing eggs can cause an allergic reaction or low blood pressure. It can also cause nausea or vomiting.

Infection:  The incidence of infection (due to bacteria from the vagina being transferred to the ovaries or pelvis) after egg retrieval is very small (less than 0.1%).  If you do get an infection, you may be given antibiotics. Severe infections sometimes require surgery to remove infected tissue. Antibiotics may be used before or during the egg retrieval to reduce the chance of infection.

Ovarian Hyperstimulation Syndrome (OHSS): Stimulating the ovaries can lead to OHSS. Signs of OHSS include increased ovarian size, nausea and vomiting, and buildup of fluid in the pelvis. The fluid accumulation can cause uncomfortable bloating and difficult breathing. In severe OHSS, woman can become dehydrated, which causes kidney and liver problems, or a risk of blood clots, kidney failure, or death. All these complications occur very rarely (in less than 1 in 1,000 cycles).

Cancer: Women with infertility are known to be at increased risk of certain cancers, so whether IVF increases the risk further is difficult to assess. In current studies that take into consideration the increased risk of cancer due to nulliparity (never having been pregnant) there does not seem to be an increased risk of cancer due to the fertility drugs alone.

Special Considerations in Egg Donation:

Donor Screening and Testing. I understand and agree that as an egg donor, I have been asked extensive questions about my age, travel, medical, genetic, psychological, sexual, and family history. My truthful answers to these questions are critical to the health and safety of the Recipient and the child that may be conceived because of this egg donation. I agree to answer these questions truthfully. I agree to notify The CLINIC of any medical condition or disease, particularly genetic diseases, which may arise in my immediate family or in me. I agree to provide medical updates and relevant information to the CLINIC should the CLINIC contact me in the future.

I also understand that this screening includes genetic screening, a physical exam, certain blood tests for infectious disease, and a psychological evaluation.

Infectious Disease Testing of the Egg Donor. I understand and consent that I must be subjected to federally mandated infectious disease testing within 30 days of the egg retrieval. I understand and agree that if I test positive for any of the infectious diseases or if there are other conditions that make the tissue ineligible for non-identified donation as mandated by federal law, that my eggs cannot be donated and that the eggs must be disposed of according to American Society for Reproductive Medicine (ASRM) Ethical Standards. I further understand that if I do not come for the testing required for these infectious diseases within 30 days of the retrieval, the eggs cannot be used and will be discarded, and this might cause severe stress for the Recipient. This will reduce my compensation.

I further acknowledge and consent that medical, psychological, genetic/infectious disease, technical or other considerations may contraindicate or preclude (make impossible) the donation of these eggs to a Recipient despite my request. I agree that the disposition of these eggs will ultimately rely on the best medical judgment of the CLINIC, and as appropriate, its employees, contractors, consultants, and authorized agents, at the time of the potential donation.

Identity of the Donor and the Recipient(s).

Laws and practices are changing surrounding disclosure of identifying information donor conceived persons. Egg donations can be to known or unknown recipients. In “known” (directed) donations, you know the identity of the Recipient(s). In “unknown” (non-identified) donations, you do not know who the recipient is, nor do who you are.

If I have chosen non-identified donation, I understand that I will not be informed of the identity (identities) of the Recipient(s) by the CLINIC. I also understand that the CLINIC will protect my identity and will use best efforts not to reveal it to the Recipient(s) or to any child or children born from this donation, except as allowed below or if a final non-appealable court order (in the CLINIC’s sole judgment) orders otherwise.

In the situation where you do not initially know the recipient, you can choose to 1. keep your identity private (ID disclosure “None”), 2. disclose your identity up front to the recipient (ID disclosure “Open”), or 3. Disclosure your identity directly to the child when the child reaches adulthood (ID disclosure “Open at Adulthood”). The Clinic is authorized to disclose based on my choice made above. The Clinic is not obligated to locate the child for disclosure, but if approached by the child, is authorized to do so.

I understand that my identity might be revealed independently of the CLINIC by, for example, through advances in Internet searches, commercial genetic testing, or my own choice by registering with a website.

I understand that if a child born from this donation has a medical or psychological need that might be met by me, that the CLINIC may elect to contact me to make a request that my identity be revealed. Such requests may be for a medical need such as a bone marrow transplant or to obtain family history based, for example, on newly discovered genetic information.

I understand that once any child or children born from this donation are deemed legal adults, they may request to know the identity of the egg donor (me). I understand that I am under no obligation to agree to respond or reveal my identity pursuant to any request except in the event of a change in the law in any relevant jurisdiction. In making your choice below, please remember that the medical program cannot guarantee anonymity and any commitments you have made with a bank or recruiting/coordinating company that may conflict with this document, cannot be overridden or superseded by this document.

I choose:

* Non-Identified donation. I am willing to provide or have the medical program provide any Recipient with non-identifying information limited to medical and biographical information about me at any time. I do not wish any other information to be provided to any recipient.
* Directed (known) donation: I am willing to provide through the medical program both medical and biographical information about me to any offspring when they reach age 18 and the following additional information [select only one]
* Non-identifying information (which may be via email or phone call) through the medical program or an assigned third-party mediator)
* Identifying exchange of information, including my name, date of birth, and last known contact information upon request of any Recipient or donor conceived offspring at age 18

X

Egg Donor Date

I understand that I have the right to consult with an attorney specializing in the field of third-party reproduction at no cost to me and enter into an agreement with any designated Recipient wherein we define each party’s rights and responsibilities.

Parental Rights and Responsibilities. I understand that all rights and responsibilities for the care of any child resulting from the donation of my eggs will be the responsibility of the Recipient(s). This includes any financial responsibilities and obligations associated with the care and upbringing of such a child.

I am aware that there are or may be laws in the state of STATE or other applicable states governing the legitimacy and legal status of children born following the use of donor eggs.

By my signature below, I give up all rights to use or make decisions about my donated eggs following this procedure. Should a child be born because of my egg donation, by my signature(s) below, I relinquish any and all rights, responsibilities, and claims I have or may be potentially be deemed to have to such a child as a result of my donating the egg for the child.

It is also possible that laws may be enacted in the future that would require the CLINIC to reveal my identity to the Recipient or resulting child. If such laws are enacted, the CLINIC might be required to adhere to those requirements.

Information on all cycles of Assisted Reproductive Technology treatment, along with data identifying Recipients and women who undergo ART with their own eggs, is currently collected into a national database under the 1992 Fertility Clinic Success Rate and Certification Act. As part of this process, the Society for Assisted Reproductive Technology plans to begin to collect identifying information on all egg donors. As with Recipient cycles and cycles for women using their own eggs, this information may be used to track outcomes.  For this purpose, certain donor identifying information such as name, date of birth, and social security number will be reported to a Registry by SART member clinics for data aggregation. ASRM guidelines currently require permanent records be kept for all egg donation cycles. Efforts to collect this information are intended to respect donation confidentiality and not to disclose confidential identifying information to Recipients, donors, or offspring. Control of such information in the future may, however, depend on applicable law.

The CLINIC does not offer legal advice on these matters and if I need or want legal advice, I must consult an attorney with expertise in family law related to assisted reproductive technologies.

Responsibilities of the Egg Donor. I understand and agree that additional responsibilities and requirements described in the Egg Donor Agreement must be met as part of the egg donation process. I further understand that adherence to the terms of that agreement will not affect the medical care that I receive, as described in this consent.

I may change my mind at any time prior to the point at which the eggs have been retrieved and donated, but not thereafter.

Other Considerations:

Confidentiality. I understand the confidentiality of medical records, including any photographs, X-rays or recordings, will be maintained in accordance with applicable state and federal laws. Anonymous data from the ART procedure will also be provided to the Centers for Disease Control and Prevention (CDC) in compliance with the 1992 Fertility Clinic Success Rate and Certification Act, which requires that CDC collect data on all assisted reproductive technology cycles performed in the United States annually and report success rates using these data.

I expect this procedure to be performed with not less than the customary standard of care. I understand the risks and benefits as outlined, and further understand and agree that the CLINIC shall be responsible only for acts of negligence on its part and the part of its employees, contractors, consultants and authorized agents.

I acknowledge that the full egg donation process has been explained to me, together with the known risks. I have had the opportunity to ask any questions I might have, and those questions have been answered to my satisfaction. Any further questions may be addressed to the CLINIC director, Dr. John Smith at (123) 456-7890.

X

Egg Donor Signature Date

Egg Donor Name Date of Birth

Notary Public (if signed out of the office):

Sworn and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_.

X

Notary Signature Date

==================================================================

Statement by Witness (must be employee of Clinic and at least 18 years of age)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Egg Donor Agreement

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, have executed (signed) an informed consent to act as an Egg Donor (ED) in the program of the CLINIC NAME (CLINIC). I understand that the consent describes the medical aspects and some of the legal issues and the risks of the treatment that I will receive as part of acting as an Egg Donor.

I understand that this agreement describes the specific responsibilities and requirements to which I have agreed in acting as an egg donor. I understand that I will be compensated for my time and effort only if I meet these responsibilities.

I understand that I have the right to consult with an attorney specializing in the field of third-party reproduction at no cost to me and enter into an agreement with any designated Recipient wherein we define each party’s rights and responsibilities. I further understand that by signing this agreement, it is only with the CLINIC and any designated Recipients are not agreeing to any obligations towards me.

By signing this agreement, I state that to the best of my knowledge, I have been completely truthful in all the information I have given in my application to be an egg donor regarding my age, personal medical, psychological, travel, sexual and genetic history and that of my family where requested.

As part of my continued participation as an egg donor, I agree to:

* Submit to any urine tests, cervical cultures, blood tests, or physical examinations required.
* Continue to truthfully disclose aspects of my age, medical, psychological, genetic, sexual, and family history.
* Refrain from smoking.
* Refrain from use of recreational drugs.
* Refrain from getting a piercing or tattoo within one-year preceding donation.
* Alert the clinic of any travel plans or if there has been any risk of exposure to disease
* Respond to requests for follow-up information in a timely fashion.
* Keep all scheduled appointments and arrive promptly.
* Follow all instructions precisely and ask for assistance if I do not understand those instructions.
* Refrain from any attempt to learn the identity of the recipients.
* If I tell others that I am an egg donor, I will not share the exact timing of my cycle or the day of my egg retrieval (except with those that live with me and the person that transports me to and from my egg retrieval).

I understand that, from the beginning of my drug treatment with GnRH agonist, antagonist or birth control pills, I must:

* Refrain from intercourse or if I have intercourse, use a condom to avoid both pregnancy and disease transmission.
* Avoid high impact and strenuous activities such as running.
* Take all medications at the prescribed time.
* Have blood tests and ultrasounds at intervals determined by the physicians, which may be daily for several weeks.
* Be available for egg retrieval on the day determined by the physicians, on 36 hours’ notice.

I understand that:

* As an egg donor and patient of the CLINIC, I will receive medical care consistent with the standards set by SART and relevant guidelines issued by ASRM.
* All reasonable efforts will be made to maintain my confidentiality and protect my identity unless at some time in the future I agree to reveal it.
* There are or may be laws in the state of STATE or other applicable states governing the legitimacy and legal status of children born following the use of donor eggs. It is also possible that laws may be enacted in the future that would require the CLINIC to reveal my identity to the recipient couple (individual) or resulting offspring. If such laws are enacted, the CLINIC might be required to adhere to those requirements.
* The CLINIC does not offer legal advice on these matters and if I need or want legal advice, I must consult an attorney with expertise in reproductive technology law.
* I will be treated with respect and care throughout the process.

I understand that:

* If I require any additional treatment for any complications that arise, I may be covered by short-term oocyte donor health insurance that will be provided to me by the program within the terms, limits and conditions of the plan. (I have been given a copy of limitations of that policy and understand that conditions that do not directly relate to egg donation may not be covered).
* I am solely responsible for the cost of any additional treatment required that is unrelated to my egg donation (that is, treatment outside of the terms, limits and conditions of the short-term oocyte donor health insurance plan provided to me by the CLINIC).
* Treatment will be provided to me by a member of the CLINIC’s medical team or other physician as indicated.
* I will be responsible for all costs associated with all deductibles, co-payments and other amounts related to non-covered services (services unrelated to my donation of eggs).

I understand that in exchange for the time and effort I expend during this cycle, the Recruiting Program will control my reimbursement if they recruited me, or the CLINIC if they recruited me.

If the CLINIC recruits me, I understand that the reimbursement rules below will apply:

* Donors are compensated $X,XXX for time and effort involved in a completed Egg Donation cycle.
* Donors will receive IRS Form 1099 from the CLINIC listing the compensation earned from egg donation. The Egg donor (me) will be responsible for all federal, state or local taxes associated with payments received from the CLINIC.
* In performing the services, duties and obligations of an egg donor it is understood that the donor and the CLINIC are acting and performing as an independent contractor with respect to the other and that no relationship of partnership, joint venture or employment is created under this agreement.
* A complete donation cycle is defined as one where the donor completes the three stages of a donor cycle: screening to become an egg donor, ovulation induction (taking the fertility drugs with required monitoring), and egg retrieval (including federally mandated infectious disease testing performed within 30 days of the egg retrieval).
* Participation is purely voluntary and refusal to participate or withdraw from the program at any time will not involve any penalty from the CLINIC other than loss of compensation amount.
* Breakdown of donor compensation for a completed cycle:

|  |  |
| --- | --- |
| Completion of Screening, Ovulation Stimulation and Egg Retrieval | $X,XXX |

* When a completed cycle is not achieved the following compensation guidelines will apply:

|  |  |  |  |
| --- | --- | --- | --- |
| Determining Party | Cause | Cycle Stage | Compensation |
| Donor | Self-select out | Anytime | -$0- |
| MD /Donor | Donor non-compliance | Anytime | -$0- |
| MD | Donor complication | Before stimulation start | -$0- |
| MD | Donor poor response |  | $XXX |
| MD | Donor hyperstimulation |  | $XXX |
| MD | Donor tests positive for infectious diseases  |  | $XXX |
| Recipient | Cancels/withdraws |  | $XXX |

I have read this agreement, understand my responsibilities, and agree to these conditions of being an Egg Donor. I have received a copy of this agreement.

X

Egg Donor Signature Date

Egg Donor Name Date of Birth

Notary Public (if signed out of the office):

Sworn and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_.

X

Notary Signature Date

==================================================================

Statement by Witness (must be employee of Clinic and at least 18 years of age)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_